Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.
- **UNKNOWN**—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE

a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY

(*Billing Office to indicate;* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment

1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***

1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN

(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]***.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS

Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING

(*With hearing appliance, if used*)

0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES

(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION

(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY

(*Code for speech in the* ***last 7 days***)

0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING

Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

3. CHANGE IN MOOD

Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

5. CHANGE IN BEHAVIORAL SYMPTOMS

Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

2.	**BATHING**	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance and support.* **(A)** BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (*Bathing support codes are as defined in* ***Item 1, code B above***)	(A)	(B)
3.	**TEST FOR BALANCE** **(see training manual)**	(*Code for ability during test in the* ***last 7 days***) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help **a.** Balance while standing **b.** Balance while sitting—position, trunk control		
4.	**FUNCTIONAL LIMITATION IN RANGE OF MOTION** **(see training manual)**	(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury*) **(A)** *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides **(B)** *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss **a.** Neck **b.** Arm—Including shoulder or elbow **c.** Hand—Including wrist or fingers **d.** Leg—Including hip or knee **e.** Foot—Including ankle or toes **f.** Other limitation or loss	(A)	(B)
5.	**MODES OF LOCOMOTION**	(***Check all that apply*** *during* ***last 7 days***) Cane/walker/crutch **a.** Wheeled self **b.** Other person wheeled **c.** Wheelchair primary mode of locomotion **d.** *NONE OF ABOVE* **e.**		
6.	**MODES OF TRANSFER**	(***Check all that apply*** *during* ***last 7 days***) Bedfast all or most of time **a.** Bed rails used for bed mobility or transfer **b.** Lifted manually **c.** Lifted mechanically **d.** Transfer aid (e.g., slide board, trapeze, cane, walker, brace) **e.** *NONE OF ABOVE* **f.**		
7.	**TASK SEGMENTATION**	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes		
8.	**ADL FUNCTIONAL REHABILITATION POTENTIAL**	Resident believes he/she is capable of increased independence in at least some ADLs **a.** Direct care staff believe resident is capable of increased independence in at least some ADLs **b.** Resident able to perform tasks/activity but is very slow **c.** Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings **d.** *NONE OF ABOVE* **e.**		
9.	**CHANGE IN ADL FUNCTION**	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***) 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
a.	**BOWEL CONTINENCE** Control of bowel movement, with appliance or bowel continence programs, if employed
b.	**BLADDER CONTINENCE** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed
2.	**BOWEL ELIMINATION PATTERN** Bowel elimination pattern regular—at least one movement every three days **a.** Constipation **b.** Diarrhea **c.** Fecal impaction **d.** *NONE OF ABOVE* **e.**

3.	**APPLIANCES AND PROGRAMS**	Any scheduled toileting plan **a.** Bladder retraining program **b.** External (condom) catheter **c.** Indwelling catheter **d.** Intermittent catheter **e.** Did not use toilet room/ commode/urinal **f.** Pads/briefs used **g.** Enemas/irrigation **h.** Ostomy present **i.** *NONE OF ABOVE* **j.**		
4.	**CHANGE IN URINARY CONTINENCE**	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	**DISEASES**	(***If none apply, CHECK the NONE OF ABOVE box***) **ENDOCRINE/METABOLIC/ NUTRITIONAL** Diabetes mellitus **a.** Hyperthyroidism **b.** Hypothyroidism **c.** **HEART/CIRCULATION** Arteriosclerotic heart disease (ASHD) **d.** Cardiac dysrhythmias **e.** Congestive heart failure **f.** Deep vein thrombosis **g.** Hypertension **h.** Hypotension **i.** Peripheral vascular disease **j.** Other cardiovascular disease **k.** **MUSCULOSKELETAL** Arthritis **l.** Hip fracture **m.** Missing limb (e.g., amputation) **n.** Osteoporosis **o.** Pathological bone fracture **p.** **NEUROLOGICAL** Alzheimer's disease **q.** Aphasia **r.** Cerebral palsy **s.** Cerebrovascular accident (stroke) **t.** Dementia other than Alzheimer's disease **u.** Hemiplegia/Hemiparesis **v.** Multiple sclerosis **w.** Paraplegia **x.** Parkinson's disease **y.** Quadriplegia **z.** Seizure disorder **aa.** Transient ischemic attack (TIA) **bb.** Traumatic brain injury **cc.** **PSYCHIATRIC/MOOD** Anxiety disorder **dd.** Depression **ee.** Manic depression (bipolar disease) **ff.** Schizophrenia **gg.** **PULMONARY** Asthma **hh.** Emphysema/COPD **ii.** **SENSORY** Cataracts **jj.** Diabetic retinopathy **kk.** Glaucoma **ll.** Macular degeneration **mm.** **OTHER** Allergies **nn.** Anemia **oo.** Cancer **pp.** Renal failure **qq.** *NONE OF ABOVE* **rr.**
2.	**INFECTIONS**	(***If none apply, CHECK the NONE OF ABOVE box***) Antibiotic resistant infection (e.g., Methicillin resistant staph) **a.** Clostridium difficile (c. diff.) **b.** Conjunctivitis **c.** HIV infection **d.** Pneumonia **e.** Respiratory infection **f.** Septicemia **g.** Sexually transmitted diseases **h.** Tuberculosis **i.** Urinary tract infection **in last 30 days** **j.** Viral hepatitis **k.** Wound infection **l.** NONE OF ABOVE **m.**
3.	**OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES**	a. _____		
		b. _____		
		c. _____		
		d. _____		
		e. _____		

SECTION J. HEALTH CONDITIONS

1.	**PROBLEM CONDITIONS**	(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*) **INDICATORS OF FLUID STATUS** Weight gain or loss of 3 or more pounds within a 7 day period **a.** Inability to lie flat due to shortness of breath **b.** Dehydrated; output exceeds input **c.** Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days** **d.** **OTHER** Delusions **e.** Dizziness/Vertigo **f.** Edema **g.** Fever **h.** Hallucinations **i.** Internal bleeding **j.** Recurrent lung aspirations in **last 90 days** **k.** Shortness of breath **l.** Syncope (fainting) **m.** Unsteady gait **n.** Vomiting **o.** *NONE OF ABOVE* **p.**

Resident _____ Numeric Identifier _____

2.	**PAIN SYMPTOMS**	(*Code the **highest level of pain** present in the **last 7 days***)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	**PAIN SITE**	(*If pain present, **check all sites** that apply in **last 7 days***)	
		Back pain **a.** Bone pain **b.** Chest pain while doing usual activities **c.** Headache **d.** Hip pain **e.**	Incisional pain **f.** Joint pain (other than hip) **g.** Soft tissue pain (e.g., lesion, muscle) **h.** Stomach pain **i.** Other **j.**
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** **a.** Fell in **past 31-180 days** **b.**	Hip fracture in **last 180 days** **c.** Other fracture in **last 180 days** **d.** *NONE OF ABOVE* **e.**
5.	**STABILITY OF CONDITIONS**	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) **a.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.** End-stage disease, 6 or fewer months to live **c.** *NONE OF ABOVE* **d.**	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	**ORAL PROBLEMS**	Chewing problem **a.** Swallowing problem **b.** Mouth pain **c.** *NONE OF ABOVE* **d.**	
2.	**HEIGHT AND WEIGHT**	*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (in.) ☐☐ **b.** WT (lb.) ☐☐☐	
3.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes **b. Weight gain**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	
4.	**NUTRITIONAL PROBLEMS**	Complains about the taste of many foods **a.** Regular or repetitive complaints of hunger **b.**	Leaves 25% or more of food uneaten at most meals **c.** *NONE OF ABOVE* **d.**
5.	**NUTRITIONAL APPROACHES**	(***Check all that apply in last 7 days***)	
		Parenteral/IV **a.** Feeding tube **b.** Mechanically altered diet **c.** Syringe (oral feeding) **d.** Therapeutic diet **e.**	Dietary supplement between meals **f.** Plate guard, stabilized built-up utensil, etc. **g.** On a planned weight change program **h.** *NONE OF ABOVE* **i.**
6.	**PARENTERAL OR ENTERAL INTAKE**	(***Skip to Section L if neither 5a nor 5b is checked***) **a.** Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% **b.** Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	**ORAL STATUS AND DISEASE PREVENTION**	Debris (soft, easily movable substances) present in mouth prior to going to bed at night **a.** Has dentures or removable bridge **b.** Some/all natural teeth lost—does not have or does not use dentures (or partial plates) **c.** Broken, loose, or carious teeth **d.** Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes **e.** Daily cleaning of teeth/dentures or daily mouth care—by resident or staff **f.** *NONE OF ABOVE* **g.**	

SECTION M. SKIN CONDITION

1.	**ULCERS (Due to any cause)**	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***	**Number at Stage**
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	**TYPE OF ULCER**	(*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	**HISTORY OF RESOLVED ULCERS**	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT**	(***Check all that apply** during **last 7 days***)	
		Abrasions, bruises **a.** Burns (second or third degree) **b.** Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) **c.** Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster **d.** Skin desensitized to pain or pressure **e.** Skin tears or cuts (other than surgery) **f.** Surgical wounds **g.** *NONE OF ABOVE* **h.**	
5.	**SKIN TREATMENTS**	(***Check all that apply** during **last 7 days)***	
		Pressure relieving device(s) for chair **a.** Pressure relieving device(s) for bed **b.** Turning/repositioning program **c.** Nutrition or hydration intervention to manage skin problems **d.** Ulcer care **e.** Surgical wound care **f.** Application of dressings (with or without topical medications) other than to feet **g.** Application of ointments/medications (other than to feet) **h.** Other preventative or protective skin care (other than to feet) **i.** *NONE OF ABOVE* **j.**	
6.	**FOOT PROBLEMS AND CARE**	(***Check all that apply** during **last 7 days)***	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems **a.** Infection of the foot—e.g., cellulitis, purulent drainage **b.** Open lesions on the foot **c.** Nails/calluses trimmed during **last 90 days** **d.** Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) **e.** Application of dressings (with or without topical medications) **f.** *NONE OF ABOVE* **g.**	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	**TIME AWAKE**	(***Check appropriate time periods over last 7 days***) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning **a.** Afternoon **b.**	Evening **c.** *NONE OF ABOVE* **d.**
(If resident is comatose, skip to Section O)			
2.	**AVERAGE TIME INVOLVED IN ACTIVITIES**	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	**PREFERRED ACTIVITY SETTINGS**	(***Check all settings** in which activities are **preferred***)	
		Own room **a.** Day/activity room **b.** Inside NH/off unit **c.**	Outside facility **d.** *NONE OF ABOVE* **e.**
4.	**GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)**	(***Check all PREFERENCES** whether or not activity is currently available to resident*)	
		Cards/other games **a.** Crafts/arts **b.** Exercise/sports **c.** Music **d.** Reading/writing **e.** Spiritual/religious activities **f.**	Trips/shopping **g.** Walking/wheeling outdoors **h.** Watching TV **i.** Gardening or plants **j.** Talking or conversing **k.** Helping others **l.** *NONE OF ABOVE* **m.**

Resident _____ Numeric Identifier _____

5. PREFERS CHANGE IN DAILY ROUTINE

Code for resident preferences in daily routines
0. No change 1. Slight change 2. Major change

- **a.** Type of activities in which resident is currently involved
- **b.** Extent of resident involvement in activities

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

2. NEW MEDICATIONS (*Resident currently receiving medications that were initiated during the* ***last 90 days***)
0. No 1. Yes

3. INJECTIONS (***Record the number of DAYS*** *injections of any type received during the* ***last 7 days****; enter "0" if none used*)

4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- **a.** Antipsychotic
- **b.** Antianxiety
- **c.** Antidepressant
- **d.** Hypnotic
- **e.** Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check*** *treatments or programs received during the* ***last 14 days***

TREATMENTS
- Chemotherapy — a.
- Dialysis — b.
- IV medication — c.
- Intake/output — d.
- Monitoring acute medical condition — e.
- Ostomy care — f.
- Oxygen therapy — g.
- Radiation — h.
- Suctioning — i.
- Tracheostomy care — j.
- Transfusions — k.
- Ventilator or respirator — l.

PROGRAMS
- Alcohol/drug treatment program — m.
- Alzheimer's/dementia special care unit — n.
- Hospice care — o.
- Pediatric unit — p.
- Respite care — q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
- *NONE OF ABOVE* — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS (**Check all interventions or strategies used in last 7 days**—no matter where received)

- Special behavior symptom evaluation program — a.
- Evaluation by a licensed mental health specialist in **last 90 days** — b.
- Group therapy — c.
- Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage — d.
- Reorientation—e.g., cueing — e.
- *NONE OF ABOVE* — f.

3. NURSING REHABILITATION/ RESTORATIVE CARE *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)*

- **a.** Range of motion (passive)
- **b.** Range of motion (active)
- **c.** Splint or brace assistance
- **TRAINING AND SKILL PRACTICE IN:**
- **d.** Bed mobility
- **e.** Transfer
- **f.** Walking
- **g.** Dressing or grooming
- **h.** Eating or swallowing
- **i.** Amputation/prosthesis care
- **j.** Communication
- **k.** Other

4. DEVICES AND RESTRAINTS (*Use the following codes for* ***last 7 days***:)
0. Not used
1. Used less than daily
2. Used daily

Bed rails
- **a.** — Full bed rails on all open sides of bed
- **b.** — Other types of side rails used (e.g., half rail, one side)
- **c.** Trunk restraint
- **d.** Limb restraint
- **e.** Chair prevents rising

5. HOSPITAL STAY(S) Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)

6. EMERGENCY ROOM (ER) VISIT(S) Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)

7. PHYSICIAN VISITS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

8. PHYSICIAN ORDERS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

9. ABNORMAL LAB VALUES Has the resident had any abnormal lab values during the **last 90 days** (or since admission)?
0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

b. Resident has a support person who is positive towards discharge
0. No 1. Yes

c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

2. OVERALL CHANGE IN CARE NEEDS Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident:	0. No	1. Yes	
b. Family:	0. No	1. Yes	2. No family
c. Significant other:	0. No	1. Yes	2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

Numeric Identifier _____

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     — Complications and risk factors that affect your decision to proceed to care planning.
     — Factors that must be considered in developing individualized care plan interventions.
     — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____

3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

= One item required to trigger

= Two items required to trigger

✱ = One of these three items, plus at least one other item required to trigger

ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1																					B2a
B2b	Long term memory	1																					B2b
B4	Decision making	1,2,3																					B4
B4	Decision making	3																					B4
B5a to B5f	Indicators of delirium	2																					B5a to B5f
B6	Change in cognitive status	2																					B6
C1	Hearing	1,2,3																					C1
C4	Understood by others	1,2,3																					C4
C6	Understand others	1,2,3																					C6
C7	Change in communication	2																					C7
D1	Vision	1,2,3																					D1
D2a	Side vision problem																						D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2																					E1a to E1p
E1n	Repetitive movement	1,2																					E1n
E1o	Withdrawal from activities	1,2																					E1o
E2	Mood persistence	1,2																					E2
E3	Change in Mood	2																					E3
E4aA	Wandering	1,2,3																					E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3																					E4aA - E4eA
E5	Change in behavioral symptoms	1																					E5
E5	Change in behavioral symptoms	2																					E5
F1d	Establishes own goals																						F1d
F2a to F2d	Unsettled relationships																						F2a to F2d
F3a	Strong id, past roles																						F3a
F3b	Lost roles																						F3b
F3c	Daily routine different																						F3c
G1aA - G1jA	ADL self-performance	1,2,3,4																					G1aA - G1jA
G1aA	Bed mobility	2,3,4,8																					G1aA
G2A	Bathing	1,2,3,4																					G2A
G3b	Balance while sitting	1,2,3																					G3b
G6a	Bedfast																						G6a
G8a,b	Resident, staff believe capable																						G8a,b
H1a	Bowel incontinence	1,2,3,4																					H1a
H1b	Bladder incontinence	2,3,4																					H1b
H2b	Constipation																						H2b
H2d	Fecal impaction																						H2d
H3c,d,e	Catheter use																						H3c,d,e
H3g	Use of pads/briefs																						H3g
I1i	Hypotension																						I1i
I1j	Peripheral vascular disease																						I1j
I1ee	Depression																						I1ee
I1jj	Cataracts																						I1jj
I1ll	Glaucoma																						I1ll
I2j	UTI																						I2j
I3	Dehydration diagnosis	276.5																					I3
J1a	Weight fluctuation																						J1a
J1c	Dehydrated																						J1c
J1d	Insufficient fluid																						J1d
J1f	Dizziness																						J1f
J1h	Fever																						J1h
J1i	Hallucinations																						J1i
J1j	Internal bleeding																						J1j
J1k	Lung aspirations																						J1k
J1m	Syncope																						J1m

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

= One item required to trigger

= Two items required to trigger

✱ = One of these three items, plus at least one other item required to trigger

ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	MDS ITEM
J1n	Unsteady gait																						J1n
J4a,b	Fell																						J4a,b
J4c	Hip fracture																						J4c
K1b	Swallowing problem																						K1b
K1c	Mouth pain																						K1c
K3a	Weight loss	1																					K3a
K4a	Taste alteration																						K4a
K4c	Leave 25% food																						K4c
K5a	Parenteral/IV feeding																						K5a
K5b	Feeding tube																						K5b
K5c	Mechanically altered																						K5c
K5d	Syringe feeding																						K5d
K5e	Therapeutic diet																						K5e
L1a,c,d,e	Dental																						L1a,c,d,e
L1f	Daily cleaning teeth	Not																					L1f
M2a	Pressure ulcer	2,3,4																					M2a
M2a	Pressure ulcer	1,2,3,4																					M2a
M3	Previous pressure ulcer	1																					M3
M4e	Impaired tactile sense																						M4e
N1a	Awake morning																						N1a
N2	Involved in activities	0																					N2
N2	Involved in activities	2,3																					N2
N5a,b	Prefers change in daily routine	1,2																					N5a,b
O4a	Antipsychotics	1-7																		✱			O4a
O4b	Antianxiety	1-7																		✱			O4b
O4c	Antidepressants	1-7																		✱			O4c
O4e	Diuretic	1-7																					O4e
P4c	Trunk restraint	1,2																					P4c
P4c	Trunk restraint	2																					P4c
P4d	Limb restraint	1,2																					P4d
P4e	Chair prevents rising	1,2																					P4e

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MDS QUARTERLY ASSESSMENT FORM
(OPTIONAL VERSION FOR RUG-III 1997 Update)

Numeric Identifier _____

A1. RESIDENT NAME
a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE
a. Last day of MDS observation period
Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE
(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY
(*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY
(***Check all*** *that resident was* ***normally able to recall during last 7 days***)
Current season **a.**
Location of own room **b.**
Staff names/faces **c.**
That he/she is in a nursing home **d.**
NONE OF ABOVE are recalled **e.**

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS
(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD
(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS
(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD
(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES
j. Unpleasant mood in morning
k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
l. Sad, pained, worried facial expressions—e.g., furrowed brows
m. Crying, tearfulness
n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
p. Reduced social interaction

E2. MOOD PERSISTENCE
One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS
(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days***—*Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

Resident_____ Numeric Identifier _____

G1.			(A)	(B)
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below

	(A)
0. Independent—No help provided	
1. Supervision—Oversight help only	
2. Physical help limited to transfer only	
3. Physical help in part of bathing activity	
4. Total dependence	
8. Activity itself did not occur during entire 7 days	

G3. TEST FOR BALANCE (see training manual)

(*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	
b. Balance while sitting—position, trunk control	

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER

(***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time	a.	*NONE OF ABOVE*	f.
Bed rails used for bed mobility or transfer	b.		

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

H2. BOWEL ELIMINATION PATTERN

Diarrhea	c.	*NONE OF ABOVE*	e.
Fecal impaction	d.		

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Indwelling catheter	d.
Bladder retraining program	b.	Ostomy present	i.
External (condom) catheter	c.	*NONE OF ABOVE*	j.

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Multiple sclerosis	w.
Diabetes mellitus	a.	Quadriplegia	z.
MUSCULOSKELETAL		**PSYCHIATRIC/MOOD**	
Hip fracture	m.	Depression	ee.
NEUROLOGICAL		Manic depressive (bipolar disease)	ff.
Aphasia	r.	**OTHER**	
Cerebral palsy	s.	*NONE OF ABOVE*	rr.
Cerebrovascular accident (stroke)	t.		

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Sexually transmitted diseases	h.
Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
Respiratory infection	f.	NONE OF ABOVE	m.

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

(*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. | | | | • | |

J1. PROBLEM CONDITIONS

(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

INDICATORS OF FLUID STATUS		**OTHER**	
		Delusions	e.
Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema	g.
		Fever	h.
Inability to lie flat due to shortness of breath	b.	Hallucinations	i.
		Internal bleeding	j.
Dehydrated; output exceeds input	c.	Recurrent lung aspirations in **last 90 days**	k.
		Shortness of breath	l.
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Unsteady gait	n.
		Vomiting	o.
		NONE OF ABOVE	p.

J2. PAIN SYMPTOMS

(*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS

(***Check all that apply***)

Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Other fracture in **last 180 days**	d.
Fell in **past 31-180 days**	b.	*NONE OF ABOVE*	e.

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	a.
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
End-stage disease, 6 or fewer months to live	c.
NONE OF ABOVE	d.

K1. ORAL PROBLEMS

Chewing problem	a.
Swallowing problem	b.
NONE OF ABOVE	d.

K2. HEIGHT AND WEIGHT

Record ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES (***Check all that apply in last 7 days***)

Parenteral/IV — a.
Feeding tube — b.
On a planned weight change program — h.
NONE OF ABOVE — i.

K6. PARENTERAL OR ENTERAL INTAKE (***Skip to Section M if neither 5a nor 5b is checked***)

a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days**
0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

b. Code the average **fluid intake** per day by IV or tube in **last 7 days**
0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

M1. ULCERS (Due to any cause)

*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

Number at Stage

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

M2. TYPE OF ULCER (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue

b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (***Check all that apply** during **last 7 days***)

Abrasions, bruises — a.
Burns (second or third degree) — b.
Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) — c.
Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster — d.
Skin desensitized to pain or pressure — e.
Skin tears or cuts (other than surgery) — f.
Surgical wounds — g.
NONE OF ABOVE — h.

M5. SKIN TREATMENTS (***Check all that apply** during **last 7 days)***

Pressure relieving device(s) for chair — a.
Pressure relieving device(s) for bed — b.
Turning/repositioning program — c.
Nutrition or hydration intervention to manage skin problems — d.
Ulcer care — e.
Surgical wound care — f.
Application of dressings (with or without topical medications) other than to feet — g.
Application of ointments/medications (other than to feet) — h.
Other preventative or protective skin care (other than to feet) — i.
NONE OF ABOVE — j.

M6. FOOT PROBLEMS AND CARE (***Check all that apply** during **last 7 days)***

Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems — a.
Infection of the foot—e.g., cellulitis, purulent drainage — b.
Open lesions on the foot — c.
Nails/calluses trimmed during **last 90 days** — d.
Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) — e.
Application of dressings (with or without topical medications) — f.
NONE OF ABOVE — g.

N1. TIME AWAKE (***Check appropriate time periods over last 7 days***)

Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
Morning — a.
Afternoon — b.
Evening — c.
NONE OF ABOVE — d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES (**When awake and not receiving treatments or ADL care**)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS (***Record the number of different** medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check** treatments or programs received during the **last 14 days***

TREATMENTS
Chemotherapy — a.
Dialysis — b.
IV medication — c.
Intake/output — d.
Monitoring acute medical condition — e.
Ostomy care — f.
Oxygen therapy — g.
Radiation — h.
Suctioning — i.
Tracheostomy care — j.
Transfusions — k.
Ventilator or respirator — l.

PROGRAMS
Alcohol/drug treatment program — m.
Alzheimer's/dementia special care unit — n.
Hospice care — o.
Pediatric unit — p.
Respite care — q.
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
NONE OF ABOVE — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

(A) = # of days administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)
b. Range of motion (active)
c. Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/prosthesis care
j. Communication
k. Other

P4. DEVICES AND RESTRAINTS

*Use the following codes for **last 7 days**:*
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

P7. PHYSICIAN VISITS

In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

P8. PHYSICIAN ORDERS

In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

Q2. OVERALL CHANGE IN CARE NEEDS

Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [*do not use for temporary visits home*]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊛	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊛	1. Male 2. Female
3.	BIRTHDATE ⊛	Month — Day — Year
4.	RACE/ ETHNICITY ⊛	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊛ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊛	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊛	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[*Complete only for stays less than 14 days*] (AA8a=8)

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	**a.** *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other **b.** *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

⊛ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊕	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊕	1. Male 2. Female
3.	BIRTHDATE ⊕	Month — Day — Year
4.	RACE/ ETHNICITY ⊕	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ⊕ AND MEDICARE NUMBERS ⊕ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊕	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊕	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	**Date of reentry** Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

⊕ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:
1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
2. Complete and attach this Correction Request Form to the corrected assessment or tracking form;
3. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
4. Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

PRIOR RECORD SECTION.
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (***In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.***)

Prior AA1.	RESIDENT NAME	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
Prior AA2.	GENDER	1. Male 2. Female
Prior AA3.	BIRTHDATE	Month — Day — Year
Prior AA5.	SOCIAL SECURITY	**a.** Social Security Number
Prior AA8.	REASONS FOR ASSESSMENT	**a.** Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. DIscharged prior ro completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9. Rentry **b. *Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
	PRIOR DATE	(***Complete one only***) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3.	ASSESSMENT REFERENCE DATE	**a.** *Last day of MDS observation period* Month — Day — Year
Prior R4.	DISCHARGE DATE	*Date of discharge* Month — Day — Year
Prior A4a.	DATE OF REENTRY	*Date of reentry* Month — Day — Year

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(*Enter total number of attestations for this record, including the present one*)
AT2.	ACTION REQUESTED	1. MODIFY record in error (*Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY.* ***Proceed to item AT3 below.***) 2. INACTIVE record in error. (*Do NOT submit an assessment or tracking form. Submit the correction request only.* ***Skip to item AT4.***)

AT3.	REASONS FOR MODIFICATION	(***If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5***) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error *If "Other" checked, please specify:* _____
AT4.	REASONS FOR INACTIVATION	(***If AT2=2, check at least one of the following reasons; check all that apply.***) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of inappropriate record d. Other reason requiring inactivation *If "Other" checked, please specify:* _____

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	**a.** (First) **b.** (Last) **c.** (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month — Day — Year

AT7. ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
e.	
f.	